MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Kindred Hospital Fort Worth 815 8TH Avenue Fort Worth, Texas 76104	MDR Tracking No.: M4-03-4890-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company 6210 East Highway 290 Austin, Texas 78723-1098 Box 54	Date of Injury: Employer's Name: April Building Services, Inc. Insurance Carrier's No.: 99A0000272098

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/27/02	03/30/02	Surgical Admission	$20,038.81	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position statement.

PART IV: RESPONDENT'S POSITION SUMMARY

"This dispute involves this carrier's payment for dates of service in dispute for which the requester charged $131,069.40 for five day inpatient stay for services that were NOT unusually extensive or costly. This carrier reimbursed the requester five days per diem ($1,118 times four) based on the TWCC Acute Care In-Patient Fee Guideline. This carrier also reimbursed the requester fair and reasonable reimbursement plus 10% for implantables."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the information provided by the carrier, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule. The provider did not submit an operative report, however, the carrier submitted a medical review indicating that a straightforward one-level fusion without intraoperative or postoperative complications.

The provider did not submit any invoices to determine reimbursement for the implantables; however, the carrier submitted an invoice indicating the cost of the implants in the amount of $4,645.00 in their response packet.

The requestor billed $11,629.32 for the implantables. The carrier paid $5,676.00 for the implantables based on a cost plus 10% approach.

Carrier reimbursed the provider a total of $10,147.72 for the hospital admission. Carrier made a per diem reimbursement in the amount of $4,471.72. Carrier also reimbursed the provider $5,676.00 for the implantables at cost plus ten percent bringing the total amount of reimbursement to $10,147.72.

Therefore, based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is not entitled to additional reimbursement.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor **is not** entitled to additional reimbursement.

Ordered by:

	Michael Bucklin	06/15/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787 Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____